Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of 2011

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public the Internal Revenue Code (the Code). Employee Benefits Security Administration Inspection Pension Benefit Guaranty Corporation ▶ Complete all entries in accordance with the instructions to the Form 5500-SF **Annual Report Identification Information** For calendar plan year 2011 or fiscal plan year beginning and ending 06/30/2013 X a single-employer plan a multiple-employer plan (not multiemployer) a one-participant plan A This return/report is for: the first return/report **B** This return/report is: the final return/report an amended return/report X a short plan year return/report (less than 12 months) Form 5558 automatic extension DFVC program C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan number ORAL & MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C. CASH BALANCE PLAN (PN) ▶ 003 1c Effective date of plan 01/01/2003 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number ORAL & MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C 13-3789526 (EIN) 2c Sponsor's telephone number 212-593-0303 41 EAST 57TH STREET, SUITE 1204 NEW YORK, NY 10022 2d Business code (see instructions) 621210 3a Plan administrator's name and address (if same as plan sponsor, enter "Same") 3b Administrator's EIN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES OF 41 EAST 57TH STREET, SUITE 1204 13-3789526 MANHATTAN, P.C NEW YORK, NY 10022 **3c** Administrator's telephone number 212-593-0303 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN name, EIN, and the plan number from the last return/report. 4c PN Sponsor's name 5a Total number of participants at the beginning of the plan year 5a **b** Total number of participants at the end of the plan year..... 0 Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)..... **6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) **b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) Yes under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)..... If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Financial Information Plan Assets and Liabilities (a) Beginning of Year (b) End of Year 407708 0 Total plan assets..... 7a 7b Total plan liabilities..... 407708 0 C Net plan assets (subtract line 7b from line 7a)..... 7с Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total a Contributions received or receivable from: 8a(1) (1) Employers (2) Participants 8a(2) (3) Others (including rollovers)..... 8a(3) -4 **b** Other income (loss)..... 8b -4 Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8с Benefits paid (including direct rollovers and insurance premiums 390300 to provide benefits)..... 8d Certain deemed and/or corrective distributions (see instructions) ... 8e Administrative service providers (salaries, fees, commissions)....... 8f 3159 Other expenses..... 8g

8h

8i

-14245

Total expenses (add lines 8d, 8e, 8f, and 8g).....

Net income (loss) (subtract line 8h from line 8c).....

Transfers to (from) the plan (see instructions)

393459

-393463

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-com	2200-25 7011	

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Part IV	Plan	Charac	teristics
railiv	ı Fiaii	Charac	teristics

- If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 9a
 - If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part	V Compliance Questions						
10	During the plan year:		Yes	No	1	Amount	
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X			
С	Was the plan covered by a fidelity bond?	10c	X				55000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		Х			
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		х			
f	Has the plan failed to provide any benefit when due under the plan?	10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X			
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h					
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i					
art							
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor 5500))					☐ Yes	X No
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Coc					Yes	X No
-	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)	0 01 00	00.011	302 O. E.		Ш	ш
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instrugranting the waiver.						
lf y	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13			- u, _		. • • • • • • • • • • • • • • • • • • •	
b	Enter the minimum required contribution for this plan year		[12b			
С	Enter the amount contributed by the employer to the plan for this plan year		[12c			
	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left negative amount)	t of a		12d			
e	Will the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No	N/A
art					<u> </u>	_	
				X Ye	s No		
ısa	Has a resolution to terminate the plan been adopted in any plan year?			<u> </u>	51		(
	If "Yes," enter the amount of any plan assets that reverted to the employer this year						
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brough of the PBGC?	under	the co	ontrol 		X Yes	s 📗 No
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the pla	n(s) to)			
1	3c(1) Name of plan(s):		13	c(2) EIN	(s)	13c(3	B) PN(s)
ORAI	& MAXILLOFACIAL SURGERY ASSOCIATES OF MANHATTAN, P.C. 401(K) PROF	1	13-378	9526		002	
Caut	ion: A penalty for the late or incomplete filing of this return/report will be assessed unless reasona	ble cau	ıse is	establis	hed.		
	r penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this re					ole, a Scl	nedule
	r Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return						

belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	07/25/2012	JOHN B. TODOROVICH
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

> Complete all entries in accordance with the instructions to the Form 5500-8F.

OMB Nos, 1210-0110 1210-0089

2011

This Form is Open to Public Inspection

	art I Annual Report Identification Information						
Fo.	r celendar plan year 2011 or fiscal plan year beginning	01/01/2	2012 and ending	06/30/20	112		
	<u> </u>						
_	This return report is tor.		e-employer plan (not multlemployer)	yer) 📗 a one-participant plan			
В	This return/report is:	X the final	return/report				
	an amended return/report	🗓 a short pl	an year return/report (less than 12 m	onths)			
C	Check box If filling under: Form 5558	=	c extension	☐ DFVC prog	ram		
-	special extension (enter desc	_		□ 2, 40 bio8	14111		
	art il Basic Plan Information—enter all requested in	<u>formetion</u>					
78	Name of plan			1b Three-digit			
	Oral & Maxillofacial Surgery Associat	es of		plan number	003		
	Manhattan, P.C. Cash Balance Plan			(PN) ▶ 003			
			:	01/01/20			
2a	Plan sponsor's name and address; include room or suite numb	er (employer.)	f for a single-employer plan)	2b Employer Iden	-		
·	Oral & Maxillofacial Surgery	(,,,	in a diagra amployor plany	(EIN) 13-37	89526		
	Associates of Manhattan, P.C.			2c Sponsor's tele			
				(212) 593	9-0303		
	41 East 57th Street, Suite 1204			2d Business code			
	New York		NY 10022	621210	(see madendia)		
3a	Plan administrator's name and address (if same as plan sponso	or, enter "Sami		3b Administrator's	EIN		
	Same		,	7-7-7-01111131101011			
				3C Administrator's	telephone number		
4	MANAGEMENT CONTRACTOR						
-	If the name and/or EIN of the plan sponsor has changed since name, EIN, and the plan number from the last return/report.	the last return	report filed for this plan, enter the	4b EIN			
a	Sponsor's name			4c PN			
5a					9		
b	Total number of participants at the end of the plan year			5a			
		5b					
C	Number of participants with account balances as of the end of complete this item)	5c					
ßа	Ware all of the plants exects during the plan year levested to		□				
b	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)						
_	under 29 CFR 2520.104-467 (See instructions on waiver eligib	ility and condit	ons.)tualinea puolic accountant (ICF		Yes No		
	If you answered "No" to either 6a or 6b, the plan cannot us	e Form 5500-	SF and must instead use Form 550	00.			
Pε	rt III Financial Information			1010			
7	Plan Assets and Liabilities	Marin Marin	(a) Beginning of Year	(b) End	d of Year		
a	Total plan assets	7a	407,70		0		
b	Total plan liabilities	7b		""	•"		
_ c	Net plan assets (subtract line 7b from line 7a)	7c	407,70	8	0		
	Income, Expenses, and Transfers for this Plen Year	4,,70,600,000	(a) Amount				
	Contributions received or receivable from:		(a) Amount	and the district contents	Total		
	(1) Employers	8a(1)					
	(2) Perticipants						
	(3) Others (including rollovers)		"				
ь	Other income (loss)		(4	7 10			
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		Wales Confidences (Estas dis Assessor College es	· · · · · · · · · · · · · · · · · · ·	(4)		
ď	Senefits paid (including direct rollovers and insurance premium		1225 Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TWEATER OF A ANALYSIS OF THE	(4) Magazara aya aya aya aya aya aya		
	to provide benefits)	8d	390,30	o			
e	Certain deemed and/or corrective distributions (see Instructions						
f	Administrative service providers (salaries, fees, commissions)	_					
g	Other expenses		3,159	9			
ĥ	Total expenses (add lines 8d, 8e, 8f, and 8g)		Programmes in the section of the sec	e province i version ne servine le	393,459		
i	Net income (loss) (subtract line 8h from line 8c)		6-1900-2009 (2009) (2000-2000-2000-2000-2000-2000-2000-200	g			
i	Transfers to (from) the plan (see instructions)		·	in	(393,463)		
For P	sperwork Reduction Act Notice and OMS Control Numbers, see the instructions		(14,245)	Marie Land Marie 1985	erandery eradikter i obs		
		101 Form 5500-91			Form 5500-8F (2011)		

	Form 5500-8F 2011	Page 2 -									
Par	t IV Plan Characteristics										
9a	a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:										
þ	If the plan provides welfare benefits, enter the applicable welfare feature	codes from the L	ist of	Plan Chare	cterist	ic Cod	les In	the Insi	ructio	ns:	
Part	V Compliance Questions										
10	During the plan year:					Yes	No			mount	
a	Was there a failure to transmit to the plan any participant contributions v 29 CFR 2510.3-1027 (See instructions and DOL's Voluntary Fiduciary	within the time per Correction Progra	riod d om)	escribed in	10a		х				•
Þ	Were there any nonexempt transactions with any party-in-interest? (Do on line 10a.)	not include transe	action	a reported	10ь		х				
C	Was the plan covered by a fidelity bond?	***************************************			10c	Х					55,000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity or dishonesty?	y bond, that was o	cause	d by fraud	10d		х				-
e	Were any fees or commissions paid to any brokers, agents, or other per insurance service or other organization that provides some or all of the transcriptions.)	rsons by an insure benefits under the	ance d	errier, 7 (See	10e		×				
f	Has the plan failed to provide any benefit when due under the plan?				10f		х				
Q	Did the plan have any participant loans? (If "Yes," enter amount as of ye	ear end.)			10a		х				
ħ		nstructions and 29) CFR	ł	10h				data ber		
1	If 10h was answered "Yes," check the box if you either provided the requexceptions to providing the notice applied under 29 CFR 2520,101-3	uired notice or one	e of th	18	101				ewe a.c		
Part	VI Pension Funding Compliance							7 3 Main 3		14, 15, 17, 1777, 11	
11	is this a defined benefit plan subject to minimum funding requirements? 5500))	(if "Yes," see inst	ructio	ns and com	plete (Sched	ule Si	3 (Form	1	∏ Yes	No.
12	is this a defined contribution plan subject to the minimum funding requir									Yes	-#-
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)								•	<u> </u>	Н
а	If a waiver of the minimum funding standard for a prior year is being amo	ortized in this plan	year,	see Instruc	ctions,	and e	nter th	ne date	of the	letter n	gnilu
16.	granting the walver	······		Man	th		Day		_ Y	ear	
	Enter the minimum required contribution for this plan year	• • • • • • • • • • • • • • • • • • • •	•				12b				
	Enter the amount contributed by the employer to the plan for this plan ye						12c	_		_	
q	Subtract the amount in line 12c from the amount in line 12b. Enter the re negative amount)	sult (enter a minu	ıs sigr	to the left	of a	‴ ├ -	12d				
0	Will the minimum funding amount reported on line 12d be met by the fun							Ye	s П	No	N/A
Part	000.00pt										
13a	Has a resolution to terminate the plan been adopted in any plan year?						ХI	/es	No		
	If "Yes," enter the amount of any plan assets that reverted to the employs					- 1					C
ь	Were all the plan assets distributed to participants or beneficiaries, transf						ntroi				
	of the PBGC?									X Yes	∏ No
	which essets or liabilities were transferred. (See instructions.) 3c(1) Name of plan(s):				T		/n\ C1	NI/X		40-10	\ F1\\-\
					\vdash	136	(2) El	14(3)	_	130(3) PN(s)
	& Maxillofacial Surgery Associates of				1						
Manh	Manhattan, P.C. 401(k) Profit Sharing Plan				13-3789526 002					02	
	on: A penalty for the late or incomplete filing of this return/report wil										
20 00	penalties of parjury and other penalties set forth in the instructions, I dec Schedule MB completed and signed by an enrolled actuary, as well as the it is true, correct, and complete.	clare that I have ex ne electronic versi	xamin on of	ed this retu this return/r	m/rep report,	ort, inc	cluding the t	g, if app sest of	olicabi my kn	e, a Sch owledge	edula and
SIGN	John B. Tot Beauton T	7-25-12 3	John	B. Too	oro	vich	1				
HERI					individual signing as plan administrator						
SIGN				B. Too							
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan				nle=							
			Liner	Herrie Of In	arvidui	ai sign	ing 85	empio	yer or	pian sp	DUROL